The Instant Insurance Guide:

Health

Info and tips for buying and using health insurance in Delaware

From

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Delaware's Insurance Commissioner

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A Message From Delaware's Insurance Commissioner Matthew Denn

Health insurance is the issue that the people of Delaware talk to me about the most. Dealing with health insurance and health insurance companies can be complicated and very confusing. That's one of the reasons my office is here.

The Consumer Services staff in the Insurance Commissioner's Office is trained and experienced in dealing with health insurance problems. Whether it's a simple question or a tough situation where someone is being denied a medical treatment, we will do everything we can to help you understand your options and will contact the insurance company on your behalf if necessary. I often take on these cases myself, because, to me, there is no more important job in our department than helping consumers.

Please contact us if you need help. We know that someone's health is often on the line.

The Basics

Many medical plans typically cover a comprehensive array of health care needs, including doctors' visits, drugs and hospital care. These benefits can be delivered in several different ways:

- **Indemnity plan.** These medical plans typically have a deductible – the amount you pay before the insurance company begins paying benefits. After your covered expenses exceed the deductible amount, benefits usually are paid as a percentage of actual expenses, often 80 percent. These plans usually provide the most flexibility in choosing where to receive care.

- **Preferred Provider Organization, or PPO.** In these medical plans, the insurance company enters into contracts with selected hospitals and doctors to furnish services at a discounted rate. As a member of a PPO, you may be able to seek care from a doctor or hospital that is not a preferred provider, but you will probably have to pay a higher deductible or co-payment.

- **Health Maintenance Organization, or HMO.** These medical plans make you choose a primary care physician, or PCP, from a list of network providers. Your PCP is responsible for managing all of your health care. If you need care from any network provider other than your PCP, you may have to get a referral from your PCP to see that provider. You must receive care from a network provider in order to have your claim paid through the HMO. Treatment received outside the network is usually not covered, or covered at a significantly reduced level.

- **Point of Service, or POS.** These medical plans are a hybrid of the PPO and HMO models. They are more flexible than HMOs, but do require you to select a primary care physician (PCP). Like a PPO, you can go to an out-of-network provider and pay more of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the cost if the insurance plan has authorized the referral.

While many health insurance plans are regulated by the Delaware Insurance Commissioner, some are not.

Other Options

Limited benefit plans provide coverage for a particular health care setting, ailment or disease. Here are some options that may be available to you:

- **Basic Hospital Expense Coverage** covers a period of usually not less than 31 days of continuous in-hospital care and certain hospital outpatient services.

- **Basic Medical-Surgical Expense Coverage** covers costs associated with a necessary surgery, including a certain number of days of in-hospital care.

- **Hospital Confinement Indemnity Coverage** covers a fixed amount for each day that you are in a hospital.

- **Accident Only Coverage** covers death, dismemberment, disability or hospital and medical care caused by an accident.

- **Specified Disease Coverage** covers diagnosis and treatment of a specifically named disease or diseases – such as cancer.

- **Other Limited Coverage.** You may purchase insurance covering only dental or vision or other specified care.

Additional coverage options provide added protection should you become disabled, require long-term care or enroll in Medicare:

- **Disability Income** provides for weekly or monthly benefit payments while you are disabled after a covered injury or sickness.

- **Long-Term Care Insurance** usually pays for skilled, intermediate and custodial care in a nursing home as well as care in other settings, such as the home, adult day care center or assisted living facility. The policy usually pays a fixed amount per day while a person is receiving care.

- **Medicare Supplemental Coverage.** The federal Medicare program pays most medical expenses for people 65 or older, or for individuals under 65 receiving Social Security disability benefits. However, Medicare does not pay all expenses. As a result, you may want to buy a Medicare Supplement policy (also known as Medigap) to help pay for certain expenses, including deductibles not covered by Medicare.

Watch Out

Here are two types of health-related services that are **not** health insurance plans:

Discount Plans or Discount Cards. You may see or receive advertisements from plans offering discounts on health care for a monthly fee. These are not health insurance plans, and participants do not have the same protections as under licensed health insurance.

Discount cards do not pay medical claims. Instead the consumer with the card is responsible for paying for services at the time care is received. Many of the discount plans do not cover all types of services and conditions. And the discount card is only good with doctors and health providers that have agreed to accept it.

Some of the discount cards use high-pressure marketing tactics and ask for a large, upfront fee. They are often advertised via spam emails, internet pop-up ads, on roadside signs or on telephone poles.

Commissioner Denn strongly recommends that you thoroughly investigate any plan promising deep discounts for a "low" monthly fee and weigh the benefits against the costs carefully.

Non-Licensed Risk-Sharing Plans. You may receive offers to join a group or association that will take your monthly payments, put them in a savings account, or trust, with other participants' money, and then help pay some of your health care costs, as needed.

Such arrangements are not insurance and the participants do not have the protections available to purchasers of licensed insurance plans. Commissioner Denn strongly recommends that you thoroughly investigate such plans before joining.

Medical discount cards and risk-sharing plans are not insurance and are not regulated by the Insurance Commissioner's Office, thus the office has no ability to force such plans to take any action should a consumer have a problem.

Ways To Save

Health insurance – whether provided by your employer or purchased independently by yourself – can be expensive. Here are some ways you can control your costs:

- If you're married and both spouses work at jobs that provide health insurance, **compare your policies** and their costs to see which one best fits your needs. Look beyond the monthly amount you must pay and closely evaluate covered services, co-pay requirements, deductibles and reimbursement levels so that you make the best choice for your family and your pocketbook.

- Many plans offer a menu of options. Review your situation regularly, and **adjust your options** to meet changing needs.

- **Stay in your network** as much as possible, making sure to obtain referrals as required.

- Many plans require **pre-certification** for certain tests and procedures. Know your plan, and make sure you comply with these requirements to avoid paying penalties.

- **Hold on to all receipts** for medical services. Even though your intent may be to always stay in-network, you never know when an accident, out-of-town emergency room visit or unexpected illness might cause you to incur out-of-pocket expenses that exceed even a high deductible.

- Check to see if your employer offers a **flexible spending account**. These plans, which allow you to set aside pre-tax dollars for medical expenses and childcare, are a good way to reduce your out-of-pocket medical costs.

- Finally, consider combining a high-deductible catastrophic plan with a **Health Savings Account,** or HSA. An HSA is a tax-sheltered savings account similar to the IRA, but earmarked for medical expenses. Deposits are 100 percent tax-deductible for the self-employed and can be easily withdrawn by check or debit card to pay routine medical bills with tax-free dollars. Larger medical expenses are covered by a low-cost, high-deductible health insurance policy. What is not used from the account each year stays in the account and continues to grow interest on a tax-favored basis to supplement retirement, just like an IRA. Some employers offer HSAs to their employees as an option.

Problems With Claims

Before you make a claim: Review your policy or employee booklet carefully to be sure the service in question is covered. Follow any managed care rules, including pre-certification requirements and use of network providers. Give claim forms to the provider, with your policy number and other identifying information.

To submit a claim properly: Find out if your provider submits the claim for you or if you need to do it. If you need to do it, review the information to be sure it is complete and correct. File it as soon as you get the bill from the provider. Send it to the right address. Keep a copy for your reference.

Time frame for claims: Delaware's "Prompt Payment" regulation basically requires the insurance company to pay a claim, reject it or ask for more information within 30 days. It also requires that a health insurance company only ask for additional information once, rather than repeatedly making requests. The company must send you an explanation of benefits that explains its decision.

If your claim is paid: If you assigned benefits to the provider, the benefit check will be sent directly to the provider. You will pay any deductibles and co-insurance. If you did not assign the benefits, the check will come to you and you will need to pay your providers for the entire amount.

If your claim is denied: The reason for denial should be stated on your explanation of benefits. If you disagree with the basis stated for denial, check your policy or employee booklet for the company's appeal procedures. The company should be able to answer procedural questions about appeals over the phone. Your appeal should be in writing and may require information from your doctor or health care provider.

If, after going through the company's appeal process, you feel that your claim was unfairly denied, contact the Insurance Commissioner's Office at consumer@state.de.us or call 1-800-282-8611. Often, companies will resolve disputes after a Consumer Services representative intervenes on the consumer's behalf.

Keeping Coverage

There are ways that you may be able to keep your health coverage for a period of time when you leave a job. The first step is to figure out if you qualify for "COBRA" and the second is to determine whether you are eligible for coverage under "HIPAA."

COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows you to **extend your current group health insurance coverage** when you leave a job, are fired from a job (for reasons other than fraud or misconduct), are reduced from full-time to part-time status, or another "qualifying event" occurs. You can extend the coverage — at your cost — for 18 months, and sometimes longer. PPOs, HMOs, indemnity policies and self-insured plans are all subject to COBRA, but your employer must have 20 or more employees.

If you leave a job and use COBRA to continue your health coverage, you will still have the same plan with the same benefits and provisions, but you will pay much more for it. That's because your employer was paying part of your premium before and now you will be responsible for paying all of the premium. Ask your employer's human resources staff to use COBRA.

If you are not eligible for COBRA, if your employer is not covered by it because the your employer has fewer than 20 employees, or if you have used COBRA and the time period has run out, you may be able to purchase health coverage under the federal Health Insurance Portability and Accountability Act, or HIPAA. If you meet the definition of an eligible individual under HIPAA, ***all health insurance companies who sell individual plans must offer you health insurance*** regardless of your medical history and even if you have a pre-existing condition.

To qualify under HIPAA, you must have had health care coverage for the last 18 months under an employer-sponsored group health plan (COBRA coverage counts). You must not be eligible for any other group health plan, Medicare or Medicaid. You must not have lost your most recent health coverage due to fraud or not paying. There are other restrictions as well. If you request a HIPAA-guaranteed policy within 63 days of losing your previous health coverage, most health insurance companies in Delaware are required to offer you a choice of two policies.

If you have questions about whether you qualify for coverage under COBRA or HIPAA, contact the Insurance Commissioner's Office at 1-800-282-8611 or consumer@state.de.us .

No Drug Coverage?

For those whose health coverage does not include prescription drugs, here are some resources on the internet for possibly obtaining needed prescriptions:

- **www.together-RX.com** (or 1-800-865-7211)
- **www.helpingpatients.org**
- **www.benefitscheckuprx.org**
- **www.needymeds.com**
- **www.pfizerforliving.org** (or 1-800-717-6005)

You may also want to speak to your doctor or medical provider about any direct pharmaceutical company programs they know of that provide prescriptions to those who cannot afford them.

Need Help?

The Delaware Insurance Commissioner's Office is here to help if you have questions about or problems with your insurance coverage or insurance company.

Questions about insurance or complaints about an insurance company or insurance agent can be made to the Commissioner's Consumer Services division by phone, by fax, by letter, by email or with an online complaint form:

1-800-282-8611 toll-free in Delaware
or (302) 674-7310

(302) 739-6278 fax

841 Silver Lake Blvd.
Dover, DE 19904

Email: consumer@state.de.us

Website: delawareinsurance.gov

Medicare, Medicare Part D, Medigap and Long-Term Care Insurance

Information and tips on Medicare, Medicare Part D, Medigap policies, long-term care insurance and other issues affecting seniors are part of the "Guide To Health Insurance for Delaware Seniors," published annually by Commissioner Denn. The guide also includes a list of rates for Medigap policies from each of the companies that offer the coverage in Delaware.

The latest version of the guide is available online at delawareinsurance.gov (click on "Guides and Publications). Or to have one sent to you, please call 1-800-282-8611.

More Online

Visit Insurance Commissioner Matthew Denn's website to find even more information and tips about health insurance:

delawareinsurance.gov

Topics covered online include:

- Specific insurance tips for ***young adults***, ***young families***, ***midlife families*** and ***seniors***
- Explanation of ***health insurance terms***
- A list of ***health insurance companies*** offering coverage in Delaware
- A list of bills in the General Assembly aiming to lower the cost of health insurance as part of Commissioner Denn's ***legislative agenda***
- Health care programs for people who ***do not have health insurance***

What To Look For In Health Insurance

If you have a choice of companies for your health care coverage, use these questions to help compare the plans:

- **What's Covered?** What does the plan pay for and not pay for? Are there limits on pre-existing medical conditions? Does it pay for preventive care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatments, durable medical equipment or chiropractic care?

- **What Are The Premiums?** How often can rates change? Do rates increase as you age?

- **What Are The Out-Of-Pocket Expenses?** What are the co-payments and deductibles you will have to pay when you receive care? Are there limits on your out-of-pocket expenses? Are there any limits on how many times you can receive a service in a year or in your lifetime?

- **What About The Company?** Check with the Department of Insurance to make sure a company is licensed to do business in Delaware, to find out its financial stability rating from A.M. Best Co., and to find out its complaint history.

Get more tips and information about health insurance from Insurance Commissioner Matthew Denn at delawareinsurance.gov

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